

**ASSEMBLY COMMITTEE ON HEALTH
ASSEMBLY COMMITTEE ON JUDICIARY**

JOINT INFORMATIONAL HEARING

Tuesday, December 18, 2001

1:30 p.m., Room 4202

AB 1600 (Keeley)

Introduction

When AB 1600 (Keeley) passed the Assembly Floor on June 6, 2001, the bill authorized health care providers, on a class basis, and health plans to agree to negotiate any contract term or condition upon renewal of a contract or during the contract term, if there is no provision for renegotiation. The measure contained a sunset date of July 1, 2004.

The bill was gutted and amended in the Senate, and the current version of the bill is on the Assembly Floor Inactive File after passing out of the Assembly Judiciary Committee on September 13, 2001. In short, AB 1600 permits any interested person to obtain equitable relief from any health care service plan (health plan) as to any violation or threatened violation of the body of law regulating health plans (the Knox-Keene Act) in any court of competent jurisdiction.

After an overview of the California health care market and a review of the Department of Managed Health Care (DMHC), the members of the Assembly Health and Judiciary Committees will hear testimony from bill's proponents, opponents, and regulators of the state's health care service plans. Included with the briefing material is a letter from Assemblymember Helen Thomson to DMHC with a list of questions, a copy of Health and Safety Code Section 1367, a Legislative Analyst's Office review of DMHC's budget and daily operations, and the Department of Managed Health Care's Record of Consumer Complaints - 2000. The following discussion questions were sent to panel participants in advance of the hearing to frame the issues and stimulate discussion on the proposed legislation.

Discussion Questions

- 1) How does the Department of Managed Health Care (DMHC) interpret subdivision (h) of Health and Safety Code Section 1367 (which requires that all contracts with subscribers and enrollees and all contracts with providers to be fair, reasonable, and consistent with the

objectives of the Knox-Keene Act)?

- 2) What does DMHC consider to be a contract with a provider that is fair, reasonable, and consistent with the objectives of the Knox-Keene Act?
- 3) Should there be additional state oversight by the Department of Managed Health Care of the terms of contracts between health plans, providers and employers?
- 4) Do current contracts between health plans and providers adversely affect access to care, continuity of care, geographic access to care, or timely access to care?
- 5) Should any interested person be able to obtain equitable relief from any health plan for any violation or threatened violation of the Knox-Keene Act in any court of competent jurisdiction? Should the interested person be required to first exhaust all available administrative remedies? What does it mean to exhaust administrative remedies?
- 6) Should health care providers, on a class basis, and health plans be permitted to agree to negotiate and mediate any contract term or condition upon renewal of a contract or during the contract term if there is no provision for renegotiation?
- 7) Should contract terms and rates between health plans and providers be determined by the market?
- 8) Will government regulation of the contractual relationships between health plans and health care providers lead to higher costs for consumers and employers?

Background

A recent review of capitation contracting in New York and California published in the journal *Health Affairs* found the atmosphere between health plans and physicians is charged with distrust and that contractual relationships between the two entities are under severe strain.¹ The median operating margin of hospitals in 1999 was -0.33% in 1999,² only 48% of the reporting risk-bearing organizations (medical groups) met all four of the reviewing or grading standards intended to measure the groups' financial solvency,³ and in the past year, the DMHC took control of one California health plan and appointed a conservator over another because of concerns about their ability to provide quality services and about the plans' financial solvency.⁴

California has one of the highest rates of HMO penetration in the country (52% compared to 30% nationally). There are over 17 million Californians enrolled in one of the state's 36 HMOs, and 78% of total HMO enrollment is concentrated in five HMOs.⁵ Physician associations have argued that the state's high managed care penetration has created a market imbalance and that physicians are leaving the state, although the ratio of California physicians to 100,000 population has increased from 177 in 1994 to 190 in 2000.⁶

Despite spending a higher percentage of its Gross Domestic Product on health care expenditures than other industrialized nations,⁷ the United States has millions of people with no health insurance. This problem is particularly acute in California, where despite paying less in health insurance premiums compared to the rest of the country,⁸ more than 6.8 million Californians were uninsured in 1999, representing 22% of the state's non-elderly residents.⁹

AB 1600 (Keeley)

AB 1600 permits any interested person to obtain equitable relief from any health care service plan (health plan) as to any violation or threatened violation of the body of law regulating health plans in any court of competent jurisdiction. Specifically, AB 1600:

- 1) Permits any interested person to obtain equitable relief from any health plan to any violation or threatened violation of the Knox-Keene Act (the body of law licensing and regulating health plans) in any court of competent jurisdiction.
- 2) States the remedy in #1 above is not exclusive, but is cumulative to other remedies or penalties available under all other laws of this state and under federal law.
- 3) Requires, for actions brought under this bill after January 1, 2002, the interested person to first exhaust all available administrative remedies.
- 4) Requires the court, if the contract between a health plan and provider expires during the pendency of an action brought under this bill, to issue an order extending the contract for a 180-day period, in order to provide continuing care to enrollees or subscribers.
- 5) Requires the current contract rates and terms to stay in effect during the 180-day period, subject to appropriate adjustment by the court to ensure enrollee or subscriber access to health care. Permits this period to be extended by mutual agreement of the parties. States these provisions do not affect the right of a licensee to terminate a contractual relationship with an individual provider consistent with the principles of *Potvin v. Metropolitan Life Insurance Co.* (2000) 22 Cal.4th 1060, whenever applicable.
- 6) Prohibits, as a defense in an action brought under this bill, that a provision of the Knox-Keene Act that is at issue has been contractually waived. Prohibits and makes unenforceable provisions of contracts of health plans or their contracting intermediaries that require beneficiaries or providers to waive any provision of the Knox-Keene Act.
- 7) Makes it unlawful for a health care service plan to terminate, retaliate against, or otherwise penalize plan enrollees, subscribers, or providers for exercising their rights under this bill.
- 8) Exempts from the provisions of this bill an enrollee or subscriber's individual grievance or complaint with a licensee that is subject to specified provisions of the Knox-Keene Act. States that nothing in this provision limits an action to obtain equitable relief from a licensee

for any violation or threatened violation of this bill if the action does not seek relief for an enrollee's or subscriber's individual grievance or complaint.

- 9) Prohibits a licensee from seeking indemnity, whether contractual or equitable, from a provider, employer, or employer group purchasing organization for any liability imposed under this bill.
- 10) Makes any waiver of this bill contrary to public policy and therefore requires it to be unenforceable and void.
- 11) Prohibits the enactment of this bill from being construed to suggest that the law in existence prior to enactment of this bill prohibits or permits the filing of an action for equitable relief by a private party for a violation of the Knox-Keene Act, and shall not in any way be deemed to affect any litigation to enforce the Knox-Keene Act that is pending on January 1, 2002.

Existing Law

The Knox-Keene Act establishes in the Business, Transportation and Housing Agency, the Department of Managed Health Care (DMHC), which is charged with the execution of the laws of this state relating to health plans and the health plan business including those laws directing the DMHC to ensure that health plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.¹⁰ The Director of DMHC is required to administer and enforce the Knox-Keene Act.¹¹ Section 1367 of the Knox-Keene Act requires, among other things, that all contracts with subscribers and enrollees, and all contracts with providers, to be fair, reasonable, and consistent with the objectives of the Act.¹²

AB 1600 Proponents

AB 1600 is sponsored by the California Medical Association (CMA), which asserts the bill would allow providers as well as enrollees to seek equitable relief in order to protect their rights under current law. CMA argues that, while one practical result of an AB 1600 action might be the reformation of the contract by the court to require a "fair and reasonable" rate of compensation, and that more adequate compensation will encourage physicians to stay in practice, and will also relieve the pressures of potential financial insolvency, which is a growing problem facing medical groups as well as individual physicians. CMA asserts that health plans' market power allows them to insist that providers accept contract terms which are unfair, unreasonable and harmful to patient care. The author states that "plans are difficult to deal with, acting abruptly and refusing to renew contracts that would provide clarity and fairness in addition to addressing patient care issues. Saddled with ambiguous and unreasonable contracts, providers repeatedly find themselves in disputes with plans over the interpretation of contract provisions. This takes time away from patient care and increases administrative costs." The author also argues that physicians do not have equal bargaining position with health plans in contract negotiations.

AB 1600 Opponents

Opponents, generally the health plans, assert that there is no justification to create a new cause of action that will result in significant litigation costs for the health plans. Opponents also contend that the bill would interfere with long established policy, generally known as the "primary jurisdiction doctrine," that courts defer to administrative agencies when the questions raised involve expertise possessed by the administrative agency and court rulings on the matter might result in inconsistent application of the laws. The California Association of Health Plans (CAHP) contends that AB 1600 is a raw attempt to increase provider reimbursement rates by creating the right for providers to sue in court to reform their provider contracts. Just the threat of a possible lawsuit could intimidate plans into providing more generous reimbursement rates, which would eventually increase health care premium costs. The health plans also argue that AB 1600 would render the new DMHC toothless and would defeat the purpose of its creation. CAHP argues that creating a private right of action to challenge and reform contracts under Knox-Keene would fundamentally affect the ability of DMHC to fulfill its regulatory mission to enforce the law to promote the delivery of medical care to the people of this state. Private judgments could significantly affect the financial health of health plans and their ability to deliver services, thus compromising the DMHC's mission.

Department of Managed Health Care

The Department of Managed Health Care does not have an official position on the current bill. DMHC has opposed prior versions of this bill, and has expressed concern on this bill and other bills considered during this legislative session, that DMHC believes would interfere with private contractual relationships between plans and providers. As an alternative to this bill, the Department has proposed establishing a voluntary system for the independent external review of disputes between health plans and contracting and non-contracting providers.

Legislative Analyst's Office

In response to a request from Assemblymember Keith Richman, the LAO undertook a comprehensive review of DMHC's budget and its daily operation. The LAO states its review of DMHC's operations suggests there are some weaknesses in the state's approach to regulation of the managed health care industry. These concerns include:

- The state's lack of sufficient information to fully assess why a number of medical groups in California are experiencing financial instability.
- Inconsistencies in the way the state regulates HMOs and risk-bearing medical groups which, like HMOs, take on significant financial risks in their operations.
- The limited role that DMHC has determined it can play in the HMO-medical group relationship despite the significant impact these contracts can have on the quality and stability of patient care.

- Potential problems resulting from the division of state regulation of the managed care industry among several different state agencies.
- The possibility that the assessments DMHC imposes on HMOs are insufficient to meet the department's statutory responsibilities.

The LAO offers several approaches to consider that would change the way the managed health care industry is regulated in California. The LAO states that some of these options may work together, while others represent alternative courses of action, and all would require substantial further study and analysis.

- *Licensing and Certification of Medical Groups.* Consider legislation similar to the measure enacted in New Jersey requiring that all medical groups be licensed or certified, with licensure required for groups which assume risk. This approach would enable DMHC to develop reporting requirements that would allow the state to collect complete and accurate data about medical groups that could identify more clearly what key factors are causing instability among California's medical groups.
- *Regulation of Medical Groups.* Consider legislation establishing regulatory requirements for risk-bearing medical groups comparable to those already in place for health insurance companies. The state could require each medical group to maintain a reasonable level of financial reserves, a minimal level of working capital, and adherence to established cash-ratio standards.
- *Expand DMHC's Role in the Health Plan-Medical Group Relationship.* A 2000 California legislative proposal which was not enacted, SB 2007 (Speier), would have significantly expanded DMHC's involvement in the health plan and medical group relationship by requiring DMHC to review every medical group contract with a health care service plan to determine if that contract compromised patient care. Based upon a review of criteria such as reimbursement methods and scope of services, DMHC could either approve the contract as proposed, or deem the terms unenforceable and recommend modifications. The LAO suggests in its letter to Assemblymember Richman that he consider that same approach in future legislation.

Potential legislation could specify certain factors that health care plans would have to take into account when negotiating capitation rates with medical groups, such as specifying the level and types of risk that providers could bear. Another approach would be to consider legislation similar to that enacted in North Carolina requiring that HMO premiums be adequate to cover anticipated costs. Implementation of any of these proposals would probably require a significant increase in DMHC's staffing and budget, although these resources could be obtained by imposing assessments on medical groups and health care plans.

- *Consolidating Regulation of the Health Insurance Industry.* State regulation of the health insurance industry is split primarily between DMHC and DOI. The LAO suggested that Assemblymember Richman may wish to consider legislation aimed at resolving some of the problems created by having two regulatory agencies oversee one industry, such as confusion and duplication of efforts in resolution of consumer complaints about health care coverage. The Director of DMHC and its Advisory Committee on Managed Care have contracted for a study of feasibility and merit of consolidating regulation of all health insurers within DMHC that is due to be completed by the end of December. The study could provide the basis for legislation for further regulatory reform of the health care industry.
- *Ensuring That DMHC Assessments Are Adequate.* Finally, the LAO suggests that Assemblymember Richman may wish to consider legislation to ensure that DMHC has the financial resources needed to carry out its present mission to regulate HMOs. The Bureau of State Audits was recently assigned an audit examining the assessments that DMHC imposes on health plans to generate revenue for the Managed Care Fund, the special fund which supports DMHC's main activities. The basis of this audit is legislative concern that the current statutory formula used to assess fees does not properly reflect the relative cost of regulating the different types of companies regulated by DMHC. The audit may also shed light on whether there is adequate funding for the department to meet its assigned responsibilities. This audit is scheduled to begin early next year and will take about four months to complete.

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¹ J. C. Robinson and L. P. Casalino, "Reevaluation of Capitation Contracting in New York and California," *Health Affairs* (17 May 2000): Web Exclusive

² M. G. Harrison, C. C. Montalvo and S. S. Fiorella, "Financial Health of California's Hospitals," (11 June 2001): Shattuck Hammond Partners.

³ Department of Managed Health, "Risk-Bearing Organizations First Quarter of 2001 Financial Reporting Results."

⁴ Department of Managed Health Care "UHP Healthcare/WATTS Health Foundation Members" and "A Message to Maxicare Enrollees."

⁵ H. H. Schauffler *et al.*, "Health Care Trends and Indicators in California and the United States - A Chartbook from the Kaiser Family Foundation," (June 2000): p. 2 and 3.

⁶ C. Dower *et al.*, "The Practice of Medicine in California" (February 2001), p. 7.

⁷ Organisation for Economic Co-Operation and Development, "Total Expenditure on Health, %GDP" Data as of 1998, updated August 3, 2001.

⁸ H. H. Schauffler *et al.*, "Health Care Trends and Indicators in California and the United States - A Chartbook from the Kaiser Family Foundation," (June 2000): p. 41.

⁹ E. R. Brown *et al.*, "Uninsured Californians in Assembly and Senate Districts, 2000," UCLA Center for Health Policy Research, (May 2001): p. 1.

¹⁰ Health and Safety Code Section 1341.

¹¹ Health and Safety Code Section 1346.

¹² Health and Safety Code Section 1367(h).